

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>STANDING STONE CARE AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 W CRAWFORD AVENUE MONTEREY, TN 38574</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  During complaint investigation of #39121, conducted on 6/28/16 - 7/5/16. no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE